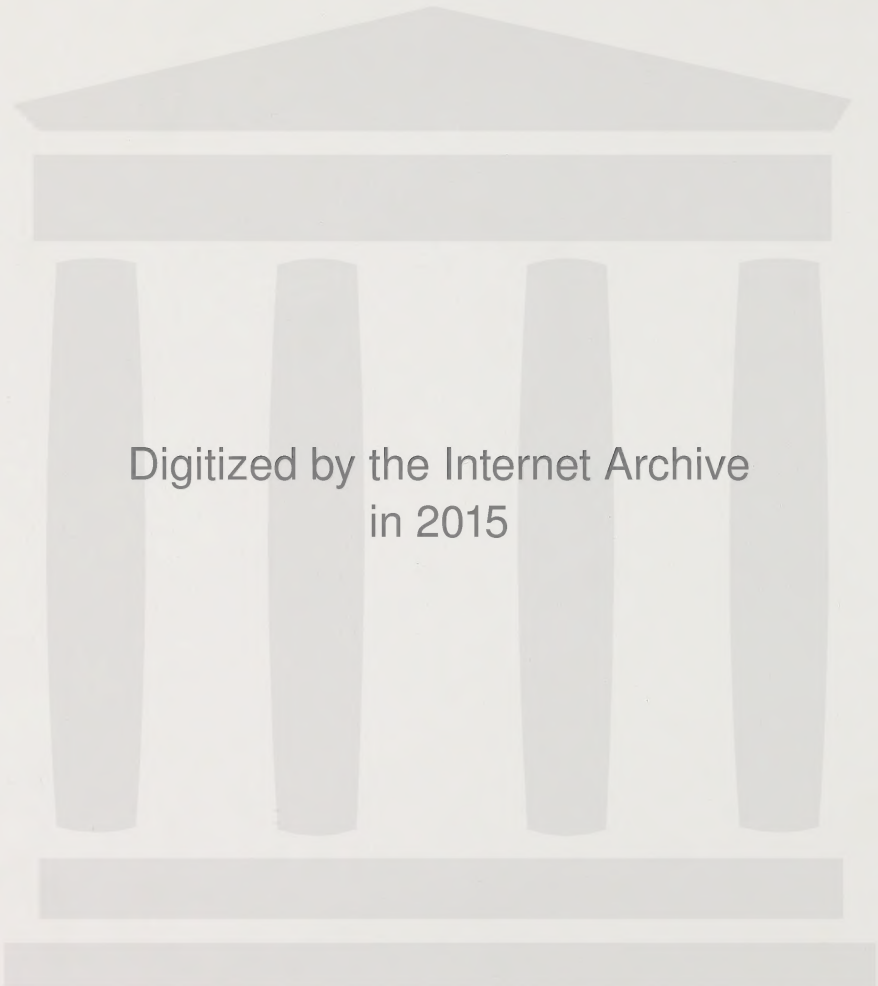
Alberta Resident Classification System for Long Term Care Facilities

Instructions for Completing the Resident Classification Form

June 1994

Alberta
HEALTH



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General Instructions

These instructions should be read before completing the Resident Classification Form (RCF) and should be kept with the RCFs as they are being completed. **Frequent reference to the instructions will be needed to complete the RCF accurately.**

1. **Sources of Information**

The resident's health care record and/or care plan are the first sources of information for all RCF items. *Written documentation of a problem, condition, or required treatment is necessary in order to be acknowledged on the RCF as present.*

2. **Time Period**

All items refer to the current status of the resident unless stated otherwise. Current status generally refers to the most recent 24-hour period. As documentation may not be done on a daily basis, the resident's health care record should be reviewed for the *past month* for documentation of the presence of a problem or condition. In some cases, confirmation of current status may be required. This should be done by consulting with the nurse in charge.

Note: It will be up to the discretion of each long term care facility to decide whether they wish to classify residents who have been admitted within the three-week period prior to classification. If long term care facilities choose to have these residents classified, they should add these names to their resident list to ensure these individuals are classified by the nurse classifiers.

3. **Level of Functioning Qualifying Information**

Some items or activities occur more than once a day and performance of the activity may vary over the 24-hour period (e.g., toileting). The level of functioning and/or the level of assistance required should be recorded according to the period specified in the item's instructions. If no time period is specified, record the resident's average requirements during the daytime.

4. **Confidentiality**

Individual resident information collected on the RCF will be kept confidential within Alberta Health and will not be released outside the department.

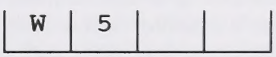
5. **How to Code Responses**

Code all items by writing the score of the selected response in the box on the right-hand side of the page.

Please PRINT all information as clearly as possible, being sure to distinguish between "4s" and "9s" and "1s" and "7s" (underline "9s" and cross "7s").

All coding boxes must be used when entering dates (i.e., if the month or day is between one and nine, it should be coded 01, 02, etc.).

When entering information in special code boxes (e.g., unit code, resident chart number, etc.), begin with the box on the left hand and enter as much information as required. Any empty boxes will therefore be to the right. For example, for the unit code:



Unless other noted, all items should be coded according to the resident's *requirements for care* as documented in the resident's care plan or health care record.

6. **Selecting Responses**

Read the indicator definition carefully.

Select the answer choice that most closely matches the description of the resident found in documentation. If the answer choice is not clear or you find conflicting information, you will need to verify the information with the nurse or therapist. Enter the possible answer choices (or a question mark) in the shaded verification strip to the left of the answer box. If verification is required, place a check mark in the circle at the top of the page.

If no frequency for an activity is specified as part of an ADL indicator's definition, then the activity must occur **at least four times a week** (i.e., more than half the time) to qualify. Code "8" (not applicable) for those activities that occur less than four times a week. For example, if a resident uses a toilet only once or twice a week because the resident is bedridden, then "8" (not applicable) is coded for Toileting.

7. **Nurse/Therapist Interviews**

After the resident's record is reviewed, it may be necessary to verify the information with the nurse responsible for the resident on the day the resident is classified. For selected items, the occupational or physical therapist responsible for rehabilitation therapy will also have to be interviewed. This will provide a second check on the data and confirm the accuracy of the information for the current day. If the nurse or therapist does not have up-to-date information on the resident, *it is his/her responsibility* to obtain the information from other staff and report it to the classifier.

Interviews with nurses/therapists should serve to verify existing information—not to provide new information. It is extremely important to ensure that interviews for verification do not change the status of the resident more than can be supported by documentation. Specific instructions provided in the classifiers' training session are to be used to guide interview questions.

- The classifier must use *only* the wording provided in each item/indicator description. Descriptions must not be reworded and further explanations must not be provided to the nurse or therapist.

- A preferred procedure is to show your pre-selected indicators to the nurse/therapist and ask her/him to indicate which statement most closely matches the resident's requirements.

- If the nurse or therapist describes the resident as being at a different level of functioning from that recorded in the health care record or care plan, the classifier should use the most current information on required care to code the indicator. At the same time, there must be supporting documentation of the problem, and the verification should be used *only to update documented information.*

- If the nurse or therapist indicates a level of functioning for which there is no evidence of a problem in the health care record, the classifier must use judgment in coding the response. This would occur only in rare cases; e.g., a change in resident status in the past 24 hours that has not yet been documented.

8. **Documentation Guidelines**

The types of charting and nursing record forms will vary from facility to facility. The amount of documentation for each resident may also vary depending on the facility's policies. To ensure consistency in

the use of documentation, particularly as it relates to incidental charting and the requirement for supporting documentation, please use the following guidelines.

- If the facility charts by exception—incidental charting—you must ask to see the written policy. The policy must clearly state the legal requirements for documentation by exception and when documentation is required. If the policy is being followed, assume that the interventions are in place unless anything about the documentation would suggest otherwise.

- The plan of care is the focus for documentation. For ADLs, BDLs and CCLs, interventions to manage the care requirements need to be documented in the care plan. Standard care plans, checklists or flowcharts may be used for documenting ADL and CCL needs and interventions. Written care plans and incidental charting as appropriate are required for BDL problems and interventions.

- When the behaviour is **predictable**—the staff know in advance when a behaviour will occur—and interventions are carried out on a **daily** or regular basis to prevent or control the behaviour, daily incidental charting is *not* necessary; e.g., during morning care, weekly bath, or activities of daily living.

- When the behaviour is **predictable** but occurs irregularly and interventions are carried out only when the behaviour occurs, then incidental charting is required each time an incident occurs. If the behaviour occurs more frequently during a shift, a summary is completed at the end of that shift. The incident and the interventions carried out should be documented; e.g., being accidentally bumped by another resident that leads to physical agression requiring an intervention of separating or distracting the residents.

- When the behaviour is **unpredictable** and results in an incident, incidental charting is required to record the incident and the interventions carried out. Any incident of unusual occurrences in respect to a resident requires notes signed and dated by the person charting them.

- When the behaviour changes or significant staff interventions are required over and above those identified in the care plan, incidental charting is required.

- If the documentation source mirrors the terminology in the Resident Classification Form, substantiation for the interventions required for the ADL, BDL, and CCL indicators must be given in another documentation source. For example, if a monthly assessment record mirrors the RCF, then the specific interventions for identified problems must be consistent with the nursing care plan.

- All documentation should be up-to-date in reflecting the **current** status of the resident. Nursing care plans and monthly/or flowsheets should be updated on a **monthly** basis. Review dates should be shown on

the documentation to identify when the resident's status was reviewed.

Facilities **may also** wish to do a brief **monthly summary** in their progress notes to confirm that the resident's status and nursing care requirements have been reviewed and to indicate whether any changes in either the resident's status or nursing interventions have occurred. If there are no changes, then a brief notation about the resident's status, including behavioural problems, may be made to indicate that the interventions will continue to be implemented as identified in the nursing care plan. Please note that it is not necessary for facility operators to do a monthly summary if other forms of documentation substantiate the current status of a resident. Also, it is not necessary to repeat the nursing care plan requirements in a monthly summary.

I. Background Data

1. **Resident AHCIP Number:** This identification number is needed to track residents within the Alberta health care system.

2. **Facility Code Number:** Use the unique code number assigned by Alberta Health to each facility as it appears on the facility's list of residents.

3. **Unit Number:** Use the code assigned by Alberta Health for the unit the resident lives in, as it appears on the facility's list of residents.

4. **Resident Chart Number:** Enter the unique number (admission number) assigned by the facility to identify each resident. If the facility does not use chart numbers, enter the AHCIP number again here.

5. **Date of Current Admission:** Enter the most recent year, month, and day the resident entered the present facility. Record the latest date of readmission even if the resident was returning following a brief discharge to another facility (i.e., if his/her bed was *not* held for him/her).

6. **Date of Birth:** Enter the resident's year, month, and day of birth in that order.

7. **Sex:** Enter a "1" for male or "2" for female.

8. **Resident Status:** Refers to the resident's **current status**. If anything other than a "0" or "1" is coded for this item, the classifier should use a short RCF which requires only the resident's label (provided by Alberta Health), the status code, the classifier code number, and date of classification.

   A "1" should be coded if the resident's chart is on the facility premises (i.e., the resident is not present in the facility, and has been absent for more than 24 hours because he/she is on leave of absence or has been temporarily transferred).

   The only exception to this is when the resident's chart is not available (i.e., resident is receiving treatment at the Cross Cancer Institute on the day of facility classification), then a short resident classification form is used.

   A "2" should be coded if the resident was classified the previous year and has since been discharged to the community (e.g., his/her private home, a group home, a senior citizens lodge, a unique home, etc.).

A "3" should be coded if the resident was classified the previous year and has since been discharged to another nursing home or auxiliary hospital (including nursing home/auxiliary hospital beds in acute care facilities). Residents transferred within a combined auxiliary hospital/nursing home should be coded "3" if the resident moved from one level to the other (e.g., nursing home to auxiliary hospital). This resident will also require a full RCF if he/she is still residing in the facility (i.e., a full RCF *and* a short RCF will be required for residents who have transferred from nursing home to auxiliary hospital and vice versa).

A "4" should be coded if the resident was classified the previous year and has since been discharged to an acute care/general hospital.

A "5" should be coded if the resident was classified the previous year and has since been discharged to an adult extended care centre (Claresholm or Raymond).

A "6" should be coded if the resident was classified the previous year and has since been discharged to a mental health hospital (Alberta Hospital Edmonton, Alberta Hospital Ponoka).

A "7" should be coded if the resident was classified the previous year but is now deceased.

An "8" should be coded only if the descriptions in 0-7 do not apply to the resident (for example, the resident was classified the previous year and has now moved out of the province). If an "8" is coded in the appropriate box for this, a description of the resident's status should be printed on the line provided.

Note: As per instructions received in training, careful note should be made of any cases in which a resident's status has changed since the facility returned its resident list.

9. **Current Marital Status:** Record a "1," "2," or "3" as appropriate to reflect the resident's current marital status. Code "2" (married) for common-law relationships.

10. **Language:** Code all three items under "Language." If the resident's preferred language is other than the six languages listed, record a "7" in the code box for "preferred language" and print the appropriate language in the area provided. If the name of this other preferred language has more than 12 letters, remove the vowels beginning at the second letter in this name until it is reduced to 12 characters (e.g., Czechoslovakian would become CZCHSLVA-KIAN).

    Note: This item refers to **demographic** information. It is not present to identify a resident's physical ability to speak. Preferred language may also be interpreted as "family language." For example, a resident may speak English with facility staff because none of the staff speaks German. With family members, however, the resident speaks German.

Frequently Asked Questions about Background Data

1. **QUESTIONS:** What if the facility does not use chart numbers (i.e., admission numbers)?

    ANSWER: Repeat the AHCIP number in this space.

2. **QUESTION:** If a resident has been living in the facility for six years, but has recently been in an acute care hospital for treatment, is the current admission date the date when the resident returned four weeks ago?

ANSWER: If the resident was discharged and his bed was *not* held, the current admission date will be four weeks ago. However, if the bed was held (i.e., the resident was not discharged and re-admitted with a new chart, etc.), the current admission date will be the original admission date six years ago.

3. **QUESTION:** The resident's month and year of birth is available, but the day is not shown. What should I do?

   ANSWER: Code "00" in the space for day of birth.

4. **QUESTION:** If a new resident was added to the master resident list by the facility when the staff were preparing for classification, but the resident has since died, what do I code?

   ANSWER: The resident will not be classified. However, to account for the name on the master list, write in "Deceased Before Classification."

5. **QUESTION:** One resident in this multilevel facility was in a nursing home bed last year, but is in an auxiliary hospital bed this year. Do I just classify him/her as auxiliary level?

   ANSWER: Two RCFs must be completed for this resident:

   - One with identifying information only to inform Alberta Health about the change (pink form—place pre-printed label on this form).
   - One complete RCF (blue form—write in identifying information on this form).

6. **QUESTION:** One of the beds in the facility is used for respite. Should I classify any resident for this bed?

   ANSWER: It will be at the discretion of each long term care facility to choose which resident they classify in this situation. Only one resident is to be classified for each bed. The resident *most familiar* to the staff is usually classified.

II. Health Status

Classifiers will be provided with a list of medical diagnoses and related ICD-9 codes from previous classification years. Facility staff will have updated these forms prior to the arrival of classifiers. If there are no changes, simply transcribe the information from the diagnosis sheet to the RCF. If the staff have added new diagnoses, include these as well with their appropriate ICD-9 code.

Note: If a diagnosis from last year is still current, but was coded as a duration of less than six months last year ("1"), be sure to change the duration code to "2" this year.

A. Current Medical Diagnoses

Using the ICD-9 code numbers on the following pages, list by disease category *all current active diagnoses* that appear in the resident's health care record. Write in the diagnosis(es) on the appropriate line *and* record the ICD-9 code in the boxes provided. More than one diagnosis may be recorded per disease category by using the second column for ICD-9 codes beside the appropriate category. If there are more than two diagnoses in one diagnostic category, use the space provided on the RCF at the bottom of the disease category list (under "other").

If a diagnostic code is not listed or if the appropriate code is not clear from the resident's record, use the "other" code designated for the specific disease category (e.g., "other circulatory diseases" ... "002"). Do not use ICD-9 codes which do not appear on the following pages. For each diagnosis, code whether the diagnosis was made less than six months ago (code "1") or six months or more ago

(code "2"). If a resident has been in the facility for less than six months and it is unclear when a particular diagnosis was made, code "1" for less than six months ago.

Frequently Asked Questions about Medical Diagnosis

1. **QUESTION:** The facility staff have entered a diagnosis that is not on the list of ICD-9 codes. What should I do?

   ANSWER: Under the appropriate category heading, enter the diagnosis as "other" in the category.

2. **QUESTION:** What if the diagnosis is not a *medical* diagnosis (e.g., bedridden, old age, glasses, incontinence, disease symptoms, surgery, etc.)?

   ANSWER: Use your judgment, but if it is not a diagnosis, do not include it. If, however, there is a diagnosis that explains the need for glasses, for example, enter the medical diagnosis.

Examples of common diagnoses from each disease category are listed on the following pages.

	ICD-9 Code Numbers
Blood and Blood Forming Organ Disorders	
Anemias	285
Polycythemia .	289
Other blood disorders	001
Circulatory Diseases	
Aneurysms	442
Angina pectoris	413
Atherosclerosis (e.g., arteriosclerosis)	440
Cardiac dysrhythmias	427
Cardiovascular disease, unspecified (e.g., ASCVD)	429
Chronic ischematic heart disease (e.g., ASHD)	414
Heart failure (e.g., congestive heart disease, acute pulmonary edema)	428
Hemorrhoids	455
Hypertension, essential	401
Hypertensive heart disease	402
Peripheral vascular disease	443
Myocardial infarction, old	412
Pulmonary heart disease, chronic	416
Pulmonary heart disease, acute (e.g., pulmonary embolism and infarction)	415
Varicose veins/stasis ulcer	454
Other circulatory diseases	002
Digestive Disorders	
Cholelithiasis	574
Chrohn's disease	555
Chronic liver disease	571
Constipation	564
Diverticula of intestine	562
Dysphagia (e.g., difficulty in swallowing)	787
Esophogeal diseases	530
Gall bladder disorders, other (e.g., cholecystitis)	575
G I ulcers	534

	ICD-9 Code Numbers
Gastritis	535
Gastroenteritis or colitis (e.g., diarrhea)	558
Hiatus hernia	553
Intestinal malabsorption	579
Intestinal obstruction	560
Kidney infections	590
Liver disorders (e.g., hepatitis)	573
Pancreatic disease	577
Other disorders of digestion and excretion	003
Endocrine and Metabolic Disorders	
Adrenal gland disorders (e.g., Cushing's syndrome)	255
Diabetes mellitus	250
Fluid/electrolyte disorders (e.g., dehydration)	276
Gout (e.g., Gouty arthropathy)	274
Malnutrition	263
Obesity	278
Pituitary gland/hypothalamic control disorders	253
Thyroid disorders	246
Other endocrine and metabolic disorders	004
Genitourinary Disorders	
Calculus of kidney and ureter	592
Chronic renal failure	585
Genital prolapse	618
Menopausal and post menopausal disorders (e.g., bleeding, vaginitis)	627
Prostate disorders	602
Urinary tract infection	599
Other genitourinary disorders	005
Mental Problems	
Alcoholism, chronic	303
Alzheimer's disease	331
Chronic organic brain syndrome	294
Dementia, arteriosclerotic, presenile and senile, multi-infarct	290
Depression	311
Down's Syndrome	758
Drug dependence	304
Korsakoff's psychosis, alcoholic	291
Mental disorder (non-psychotic) following organic brain damage	310
Mental retardation	319
Neurotic disorders (e.g., anxiety states, phobic disorders, hypochondriasis, obsessive-compulsive disorders)	300
Paranoid states	297
Psychoses, affective (e.g., manic depression)	296
Psychoses, other nonorganic (e.g., conditions provoked by emotional stress/environment)	298
Schizophrenia	295
Senility without psychosis	797
Other mental problems	006
Musculoskeletal Disabilities	
Arthritis, excluding osteoarthrosis	716
Bone infections (e.g., osteomyelitis)	730
Degeneration of intervertebral, cervical, thoracic or lumbar disc	722
Disorders of synovium, tendon and bursa (e.g., bursitis)	727
Fracture, neck of femur (e.g., head of femur, hip)	820
Fracture, other/unspecified parts of femur	821
Fracture, humerus	812
Fracture, radius and ulna	813
Fracture, vertebra	805
Fracture, other	829
Osteoarthritis	715
Osteoporosis	733
Rheumatoid arthritis	714
Spondylosis	721
Traumatic amputation of leg, late effect	905
Other musculoskeletal disorders	007

ICD-9 Code

	ICD-9 Code Numbers
Neoplasms	
Carcinoma of brain	191
Carcinoma of female breast	174
Carcinoma of colon	153
Carcinoma of lung, trachea and bronchus	162
Carcinoma of prostate	185
Carcinoma of skin	173
Carcinoma of stomach	151
Carcinomatosis, generalized cancer	199
Leukemias	208
Other neoplasms	008
Neurological Motor Dysfunction	
Amyotrophic lateral sclerosis	335
Aphasia/Dysphasia	784
Cerebral degeneration, other	331
Cerebral palsy	343
Cerebrovascular accident, acute phase	436
Cerebrovascular accident, late effects	438
Cerebrovascular disease, other	437
Convulsions	780
Epilepsy	345
Head injury	854
Hemiplegia	342
Huntington's chorea	333
Multiple sclerosis	340
Occlusion of cerebral arteries (e.g., cerebral thrombosis, embolism, infarction)	434
Paraplegia and quadriplegia	344
Parkinson's disease	332
Peripheral neuropathies	356
Poliomyelitis, late effects	138
Transient cerebral ischemia (e.g., TIA)	435
Other neurological dysfunction	009

	ICD-9 Code Numbers
Pulmonary Disease	
Asthma	493
Bronchitis	490
Chronic sinusitis	473
Chronic obstructive pulmonary disease (COPD)	496
Emphysema	492
Pneumonia	486
Pulmonary tuberculosis	011
Upper-respiratory infection, acute	465
Other pulmonary disease	010
Sensory Disorders	
Blindness and low vision	369
Cataract	366
Glaucoma	365
Hearing loss (e.g., deafness)	389
Retinal disorders	362
Other sensory disorders	012
Skin Disorders	
Chronic skin ulcer (e.g., decubitus ulcer)	707
Dermatitis/Eczema	692
Psoriasis	696
Shingles	053
Other skin disorders	013
Infectious Diseases	
Hepatitis B	070
Pulmonary tuberculosis	011
Other infectious disease	014

B. Medical Condition

For a YES to be coded for either of the two medical condition items, all of the following must be true:

- Condition must currently exist.
- Written support as to *cause and treatment plan* must appear in medical record.
- See definitions below. Examples are for clarification and are not intended to be all-inclusive.

If written documentation is not available, code a "0" for these conditions.

Medical Condition Definitions

Comatose: Unconsciousness, cannot be aroused, and at most can respond only to powerful stimuli (e.g., brain insult, hepatic encephalopathy, or cardiovascular accident).

Terminally Ill: Professional prognosis (judgment) is that resident is rapidly deteriorating and will likely die within six months (e.g., end-stage carcinoma, renal disease, cardiac disease, or those residents receiving palliative care).

C. Memory and Orientation

These items refer to behaviour exhibited by residents in the facility and observed by staff. To complete the items on *orientation to environment* and *recognition of staff*, consult the nurse in charge, or occupational or physical therapist. (Note that the resident is expected to find his/her way around only those areas of the facility to which he/she has routine access.)

To complete the item on *ability to remember instructions*, first consult the facility's occupational therapist (OT) or physical therapist (PT), since this is a routine part of his/her assessment. If no rehabilitation services are available in the facility or the PT/OT cannot answer this item, ask the nurse in charge for the information. For this item, the resident should receive the lowest applicable score (e.g., if "0," "1," "2," and "3" all apply to an individual, a "0" should be coded). The emphasis in this item is on the resident's *memory*. Repetition of sentences can be done verbally or using other communication methods such as sign language or a language board. It may also be helpful to substitute the word "recognize" or "remember" for "repeating sentences." If it is not possible to determine an individual's score on this item due to a language barrier or inability to use sign language, code an "8" for "not applicable." For all three items, "not applicable" means unable to assess. "Bedridden" and "comatose" are example reasons why these items may not be assessed.

D. Special Programs

These are programs providing specialized services which are *approved* by Alberta Health and defined as follows:

Mentally Dysfunctioning Elderly: An approved program with designated beds that provides specialized services to individuals with moderate to severe dementia with associated problem behaviours, with or without major physical care requirements.

Young Physically Handicapped: An approved program with designated beds that provides specialized services to adults mostly between 18 and 45 years of age who have a physical disability which is chronic in nature and which interferes with ADL functioning. These services are intended to maximize the resident's potential, with the ultimate goal of reintegration into the community.

Other: Any other approved programs with designated beds and/or those approved programs without designated beds (e.g., day hospital).

Note: Both boxes must be filled in. If the resident does not participate in any approved programs, code "0" in both boxes DIA and DIB. If the resident participates in only one approved program, place the approximate code in box DIA and a "0" in DIB. If the resident participates in more than one approved

program, record the code for one program in DIA and the second in DIB.

E. Frequently Asked Questions about General Classification Procedures

1. **QUESTION:** The facility uses standard care plans. They are individualized on a daily "tick" sheet, but there are no progress notes. How do I interpret this?

   ANSWER: Standard care plans are very effective for *predictable* or *usual* problems (ADLs, CCLs). They are used routinely in most health care facilities, and are acceptable as part of care plan information. In most cases, when standard care plans are in place as a part of the resident care plan, the nursing interventions are indeed being implemented. Flow sheets are acceptable forms of substantiation. Progress notes are not needed.

   If standard care plans are being used for *unusual* or *unpredictable* problems (BDLs), you should be looking for strong evidence of substantiation, particularly in progress notes. (Written care plans are expected for behavioural problems and interventions.) The key issue will relate to the frequency and duration (if ineffective coping) of the interventions required.

   During your orientation to facility records, you should clarify how standard care plans are used, if the facility has them. How standard care plans are customized to a situation should also be addressed.

2. **QUESTION:** What do we do when a facility uses charting by exception?

   ANSWER: Charting by exception is an increasingly common practice to reduce time spent in documentation. When a facility charts by exception, you must first ask to see the written *policy*. If the policy is being followed, there is no reason to think that staff are not carrying out interventions in the care plan just because there is no daily (or even less frequent) charting. Assume that actions are in place unless anything about the documentation would indicate otherwise. Some facilities will have flow charts to tick what is being done. If flowcharts are available, they should be used. (Flowcharts may be available in all three domains: ADL, BDL, CCL.) Verification may be necessary.

3. **QUESTION:** If I am uncertain about the right answer selection when I know that the resident is fairly dependent (e.g., I know the answer is either code "3" or code "4"), should I give the facility the benefit of the doubt?

   ANSWER: If you are uncertain about an answer, your first option is to code "3/4" in the verification box and then verify with the nurse. This should determine the correct response. If you remain uncertain after verification with the nurse, you will have to use your best judgment. Typically, this will mean that you make your selection on the basis of all that you know about the resident in relation to this indicator. In most cases, however, the nurse will be able to clarify which of your two options is the correct answer. As long as the nurse selects an answer that was in the range that you questioned, in most cases there is no reason not to accept that answer.

4. **QUESTION:** If I have a question about an indicator while I am reviewing a resident record, can I talk to my partner who is with me in the same facility and discuss how he or she would answer the question?

   ANSWER: If you have a question about an indicator, you should use the telephone hot-line that is in place specifically to answer classification questions and ensure consistent

interpretation in all facilities.

5. **QUESTION:** Can problem lists be used to determine classification responses?

   ANSWER: Problem lists do not usually include interventions. Unless specific interventions have been identified, you will have to review other documentation to determine classification responses. Remember that you can go back in progress notes to review the documentation for *one* month to determine answer selections.

6. **QUESTION:** Can there ever be a situation where a resident with Alzheimer's will not have some level of intervention for potential for injury? When the behaviours related to Alzheimer's are identified, it will be obvious that interventions are required, whether there is documentation or not.

   ANSWER: You should never use diagnosis to conclude anything about classification information. Remember, as a classifier, you have to take off your nurse's cap and withhold your skill at assessment to focus only on "the facts"—i.e., what is actually being done for the resident based on what you find in documentation. Your personal experience with Alzheimer's residents is not relevant. You must find evidence of interventions in the documentation for potential for injury before you can consider an answer for that indicator.

7. **QUESTION:** If the Interrater Reliability Tester (IRT) comes to visit the facility and we are almost finished with classification, is it all right to reclassify a resident for my IRT test that I have previously classified?

   ANSWER: No. If insufficient residents are available who have not yet been classified, you should select residents for classification from those classified by your partner in the facility. In other words, you are not to be tested on residents already classified by you.

8. **QUESTION:** When I am being tested by an IRT, am I able to change my answer when we are doing the verification interview?

   ANSWER: If you ask a question for verification and you determine, based on the response, that you want to change your answer, you are able to do so.

9. **QUESTION:** What do we do if the facility does not want us to do an orientation session for the staff?

   ANSWER: Although you will not be off to a good start if you insist on doing something that the facility does not want, you should carefully explain to the facility that some of the staff who will be on the units may not have been present during last year's classification and will be unfamiliar with the procedures. Suggest that a brief orientation session will be of benefit to the staff if they know what to expect and what they are to be doing. It also provides the staff an opportunity to ask questions about the classification process and to become more comfortable with it. If these suggestions are still resisted, you should probably proceed with classification. When you get to each nursing unit, you may want to ask the nurse in charge if you could give a five-minute overview for the nursing staff so that they know what to expect, especially for verification procedures. If they decline this invitation, you should go ahead with classification. Remember that each nurse that you verify with may require a brief explanation of the procedure before you begin.

10. **QUESTION:** When I am verifying with the nurse, should I just tell her/him what I think the answer is and ask her to verify

that?

ANSWER: In most cases, when you want to verify, your reason for verification will be that you are uncertain between two or more answer choices. Although you may be inclined to select one of those two, your reason for verification is to get further information from the nurse. The best procedure in verification is to allow the nurse to look at a blank RCF and ask her to choose between the two answer choices you have already selected for a particular indicator. This keeps the verification procedure as open-ended as possible. You should not be prompting or trying to put words in the mouth of the verification nurse. If the nurse happens to give you an answer choice that is not one of the two you have pre-selected, you must make a decision about whether you would change your response from one of the two that you have selected. Unless there is valid evidence that the nurse's selection is correct, you must make your decision based on what you found in documentation.

11. QUESTION: Do we have to verify everything that we have not found information about in the documentation?

    ANSWER: For non-classification items, particularly those that relate to information that is not typically kept in the record (e.g., the memory and orientation, communication, and external demand level questions), it is okay to ask the nurse in the verification interview. However, for classification items, if there is no documentation, it is interpreted that there is no need for intervention and the lowest possible score is recorded.

12. QUESTION: The facility that we are in today has care plans for its residents but some of them appear to be at least four years old. Can we use them?

    ANSWER: Most facilities have developed a procedure for updating care plans, where the dates for identified problems and interventions are updated with each regular review of the resident. If the facility that you are visiting does not appear to have such a procedure, you must first confirm with the facility that they do regular reviews but do not update the dates for problem identification and intervention. If that is the practice in the facility, there is no reason not to use the information. Obviously, you will be looking carefully at progress notes and other more current data to ensure that what is written in the care plan is indeed current.

13. QUESTION: If the care plan dates are over three months old, can we use the data?

    ANSWER: Check the facility policy regarding how care plans are updated. It is quite reasonable that some residents may have had no change in their needs for several years. If the policy is that dates are not changed after problems are first identified, you can use the care plan. Careful review of substantiating information from other sources should be included in your review.

III. Activities of Daily Living

In arriving at the ADL indicator scores, determine how the resident completed each ADL on the day of classification. Specific instructions for dealing with variability of performance during the 24-hour period are listed below for each indicator.

A. Definitions

The following terms are used in the ADL indicators:

Supervision: Verbal encouragement and observation, not physical hands-on care.

Assistance: Physical hands-on care.

Intermittent: Staff person does not have to be present during the entire activity, nor does the help have to be on a one-to-one basis.

Constant: One-to-one care requiring a staff person to be present during the entire activity; otherwise the activity will not be completed by the resident.

Note how these terms are used together in the ADLs. For example, there is intermittent supervision and intermittent assistance.

B. Clarification of ADL Responses

Eating: Level of functioning for *most of the meal times during the daytime.*

The resident may require a staff person's continual presence and help because the resident tends to choke, has a swallowing problem, is learning to feed self, or is quite confused and forgets to eat. If a resident is at risk for choking only during eating, code only under the Eating indicator. If choking occurs at other times, code under Eating and Potential for Injury.

Toileting: Level of functioning *during the daytime.*

If the resident has both an indwelling catheter and an ostomy, or uses incontinence products (e.g., pads or diapers such as "Attends") and is not taken to the toilet, code "8." Incontinence is captured under Continuing Care Level, Section V, of the RCF.

Transferring: *Highest level* of assistance required during 24-hour period.

Exclude transfers to bath and toilet. Also exclude positioning and turning. To justify coding "4," there must be a logical medical reason why the resident needs the help of two people to transfer. For example, two people may be required because the resident is obese, has contractures, has fractures (or stress-fracture potential), or has attached equipment that makes transferring difficult (for example, tubes). A two-person transfer may be required for the protection of the resident and also for staff. Note that a two-person transfer requires specification of whether the resident is able to bear weight (4.1) or not (4.2) (code a "1" or "2" in the box labelled C4). If a two-person transfer is not required, code "0" in box C4.

Dressing: Level of assistance required to dress *for the first time during the day.*

If the resident is ill in bed and clothed only in gowns and pajamas, code "8."

C. Rehabilitation for ADL Domain

The goal of the program as documented in the health care record should be used to identify the type of program the resident is on. Be sure to check with the occupational and physical therapists in the facility if there is no documentation in the record.

Definitions

Consult: A requested assessment for a specific problem that can be resolved without the resident being on a regularly scheduled intervention or treatment.

Monitor: A scheduled intervention to check or monitor the ongoing status of the resident.

Low Maintenance: The goal is to ensure that the resident remains at the optimal functional level allowed by the disease process with minimal or decreasing intervention. This resident is at a plateau.

High Maintenance: The goal is to provide a continuing program of therapy which will:

- Maintain physical and mental status at optimum levels.
- Ensure continuing comfort (pain management).
- Maintain a therapeutic environment for optimal resident functioning.

Restoration: Goal is to improve optimal functional level within a specified time frame or to achieve possible discharge.

D. Frequently Asked Questions about ADL Indicators

1. **QUESTION:** The care plan indicates "encourage patient to eat from the four food groups" or "encourage fluids." Do I code the Eating indicator to require intermittent supervision, with or without physical assistance?

   ANSWER: No. Remember that the definition of the Eating indicator is "the process of getting food into the stomach." The fact that this resident requires encouragement to eat a variety of foods does not apply. You should, however, look to see whether there are behaviour issues that would need to be supported for eating.

2. **QUESTION:** If a resident is at risk for choking, should I always code constant supervision under the Eating indicator?

   ANSWER: No. You need to find in the documentation what interventions are required. Although you would expect that such interventions are required, the documentation must support this. If the resident is at risk for choking *only* during mealtimes and requires constant supervision at this time, code the Eating indicator *only*. If interventions are also required at other times, the Potential for Injury indicator may also apply.

3. **QUESTION:** If the care plan states that the nurse has to remind the resident to go to the dining room for meals, do I code "1" or "2" for the Eating indicator?

   ANSWER: Remember that the Eating indicator is defined as "the process of getting food into the stomach." Encouraging the resident to move to the dining room does not qualify under this definition. Therefore, unless other assistance is required, you would code "0."

4. **QUESTION:** If staff are feeding two or three residents at a feeding table, is this constant encouragement or complete feeding? (The residents do not do anything for themselves.)

   ANSWER: If each resident needs to be and is being completely fed, then complete feeding (code "4") applies to each one. However, residents who are able to feed themselves, but need continuous encouragement/prompting to feed themselves, would be coded a "3."

5. **QUESTION:** If a bedridden resident is placed on a bed pan every two hours, and requires assistance getting on and off the pan, adjusting his/her clothes, and cleaning him/herself, does the Toileting indicator apply?

   ANSWER: Yes. The Toileting indicator refers to transferring on and off toilets or commodes and other toileting equipment. A bed pan is included in this definition. Remember that activities must occur at least four times a week to qualify for an ADL indicator.

6. **QUESTION:** If the facility toilets a resident on a commode three times a week, following the administration of a suppository, but otherwise the resident is incontinent and wears diapers, how do I code Toileting?

   ANSWER: Because this resident is *usually* not toileted (i.e., less than four times a week), you code "8" for Toileting.

7. **QUESTION:** If a resident is physically unable to get to the toilet but is alert and

able to notify staff when he needs to go, how do I code the Toileting indicator? He would be incontinent if he were not taken to the toilet by staff. What about the Continence indicator?

ANSWER: Two indicators, Toileting and Continence, are being addressed in the question. First, the Toileting indicator refers to the "process of getting to and from the toilet." Code the response that relates to the level of assistance that the resident requires for this indicator. You indicate that the resident requires some assistance, but not how much.

With regard to continence, you need to determine if the toileting routine is part of a management procedure controlling continence, or if the resident is only occasionally incontinent when he has to wait too long. From the way you have stated your question, it sounds as though the resident is indeed continent. If the resident is incontinent only when he has to wait too long, code "0."

8. QUESTION: How do you code the indicators Transferring and Toileting in a facility that has a mechanical lift that only requires one person to operate?

   ANSWER: Although most mechanical lifts require two people by policy, if the mechanical lift requires only one person from the beginning to the end of the procedure, you will code only that the resident requires assistance by one person (i.e., code "3"). If two people are required during any part of the process, code "4."

9. QUESTION: This resident requires a two-person transfer for Toileting. I have coded "4" for Toileting and "4" for Transferring. Is that correct?

   ANSWER: If the only time the resident requires a two-person transfer is for toileting, it is not correct to also code "4" for transferring. If the resident is transferred on other occasions, you would code according to the level of assistance required. Remember, the Transferring indicator excludes transfers on and off the toilet.

10. QUESTION: If a resident is bedridden and is transferred to sit up in a chair twice a week, how do I code the Transferring indicator?

    ANSWER: For the Transferring indicator to apply, the transferring activity should happen at least four times a week. If the resident requires transferring four times a week, code the answer that reflects the highest level of assistance required when the resident is transferred. Otherwise code "8"—the resident is bedridden.

11. QUESTION: If a resident changes clothes several times during the day, do I code "4" to account for the additional time spent by nursing staff?

    ANSWER: No. The Dressing indicator applies to the level of assistance required for the first time in the day. Multiple dressing changes may indicate a behaviour problem. If interventions are required to deal with the problem, then this information will be considered under behaviours; i.e., Ineffective Coping.

IV. Behaviours of Daily Living

The behaviours of daily living focus on behaviours that residents exhibit and the interventions that are required as a result of the behaviours. In this section, information is provided about the examples of behaviours that residents may exhibit (IV. A, page 5, Resident Classification Form [RCF]) and the

guidelines to be used by classifiers to accurately code the classification indicators—Potential for Injury and Ineffective Coping (IV. B and IV. C, page 7 of RCF).

A. Examples of Behaviours

The fifteen examples of behaviour (IV. A, RCF) are intended to provide data on specific behaviours that the resident exhibits. Reviewing these specific examples should aid the classifier in determining the appropriate level of care required on the two BDL classification indicators—Potential for Injury to Self and Others and Ineffective Coping—even though there is no direct formula for translating presence of specific behaviour into these care requirements.

The examples of behaviour are not an exhaustive list. If other problem behaviours or risk factors requiring intervention are present they should be noted under "other" (IV. A.15, RCF). For example, manipulative behaviour or poor judgement could be included by coding a "1" in box A.15 next to the "other" behaviour item, and then printing a description of the behaviour in the space provided under this item.

If a number of other behaviour/risk factors requiring care are present, list those requiring the highest level of intervention, as space permits. If the resident does not exhibit any "other behaviours/risk factors requiring care," code a "0" in box A.15 *(do not leave this box blank).*

The intent of the examples is to describe behaviours that are occurring and require some sort of intervention. It is possible that a behaviour is being managed/prevented because specific interventions are being used. If a behaviour is not occurring at the time of classification because an intervention is successfully managing/eliminating the behaviour, you may have to verify what the behaviour would be if the intervention was not applied.

Definitions

The terms used on the RCF should be interpreted only as they are defined below.

Unpredictable Behaviour: Staff cannot foretell when (that is, under what circumstances) the resident will exhibit the behavioural problem. There is no evident pattern.

Predictable Behaviour: Based on observations and experiences with the resident, the staff can discern and plan in advance when a resident will exhibit a behavioural problem. The behavioural problem may occur during activities of daily living (for example, bathing), specific treatments (for example, contracture care, ambulation exercises), or for a logical reason, such as being wrongly criticized, bumped into, etc.

Intermittent/Occasional: Behaviours occurring one or two times per month.

Frequent: Behaviours occurring at least weekly and maybe daily.

Constant: Behaviours occurring many times throughout the day or night; i.e., the behaviour is repeated numerous times throughout the day or night.

Supervision: Verbal encouragement and observation, not physical hands-on care.

Assistance: Physical hands-on care.

Intervention: Any physical, nursing, medical, or pharmacological interventions aimed at limiting, controlling, or eliminating behavioural problems. Interventions can include redirection, behaviour modification or retraining, social interventions, or restraint (physical or chemical).

B. Potential for Injury to Self and Others

Potential for injury to self and others refers to all types of behaviour or physical risk factors that might put the resident or others at risk and, consequently, require intervention. The intervention is aimed at reducing or removing the risk of the potential for injury to self or others. Residents whose physical

condition or tendency towards violence contributes to the risk are included.

In addition to the 14 behaviours identified in Section A, examples of **"other"** physical risk factors or conditions that qualify under Potential for Injury include:

- Memory and orientation problems that place the resident at risk. (However, this does not imply that all residents with memory or orientation problems are at risk for injury.)
- Judgment and decision-making abilities that are extremely poor or nonexistent.
- Risk of seizures requiring monitoring and/or accompaniment off the unit.
- Risk for falls. This risk may be a result of unsteady gait, dizziness, lack of balance, etc.
- Choking (if choking occurs outside of mealtimes).
- Noncompliance with diabetic diet.

Note: The examples of physical conditions/risk factors listed above should be recorded in the "other" behaviour (IV. A.15, RCF).

Examples of "other" physical conditions/risk factors that do ***not*** qualify under Potential for Injury are:

- Immobility.
- Poor skin integrity/preventive skin care.
- Risk for infection.
- Hearing or vision impairment, unless specifically related to uncorrected problems that put the resident at risk.
- Diabetes.
- Shortness of breath, angina, hypoglycemia, etc.
- Obesity.
- Urinary tract infection.
- Self-medication.
- Oxygen therapy, unless a resident's behaviour creates a potential for injury, such as wrapping tubing around the neck or disconnecting the oxygen.

Interventions—Potential for Injury

The Potential for Injury indicator is intended to reflect the amount of care the resident requires to control the behaviour in question during the waking hours. The need for intervention during the 24-hour period should be recorded (i.e., in the care plan), whether or not the behaviour occurs (i.e., if intervention is actually preventing the behaviour and continues to be necessary to prevent the behaviour).

Staff need to be alert to the tendency to regard chronic behaviour patterns as "normal." If behaviours are well-controlled or managed effectively, staff often forget to keep documentation current.

Interventions may be any physical, nursing, medical, or pharmacological intervention aimed at limiting, controlling, or eliminating behaviour problems. The interventions can include redirection, behaviour modification or retraining, social interventions, or restraint (physical or chemical).

Interventions aimed at reducing or removing the risk of potential for injury tend to be **scheduled** interventions that occur at regular intervals.

Guidelines for Scoring Interventions—Potential for Injury

For potential for injury to qualify as present, a statement of **planned intervention** for the identified behavioural problem must be documented on the care plan. The documentation must indicate that the behaviour is currently an **assessed need**, what

intervention controls the behaviour, and the **frequency** with which the intervention occurs. If the interventions are not identified on the care plan but are evident as documented in progress notes, then the Potential for Injury indicator qualifies for verification. If **no** statements of planned intervention for the behavioural problems are found in any of the documentation sources, then the indicator does not qualify for verification and is scored as "0."

When interventions are documented, select the score that most closely describes the level of intervention required. The times given with the intervention descriptors refer to the **frequency** of the intervention and are **not cumulative** over a 24-hour period. If more than one behaviour/risk factor is present, use the behaviour/risk factor requiring the **most** intense intervention to determine the level of intervention.

Some interventions that deal with the potential for injury are done as a result of a facility policy. The facility policy must be reviewed. Where the interventions are a result of facility policy, rather than an assessed care requirement of an individual resident, the scoring guidelines for the indicator are adjusted.

- **Restraints:** Many facilities have a policy that residents in restraints must be checked every 15 minutes. Often this check involves only monitoring by the nursing staff without any specific intervention (i.e., hands-on care) being carried out. In these cases, the intervention receives a score of "1." If a hands-on intervention is required when the checks are done, such as repositioning a resident who is slipping in the chair, then a higher score may apply, depending on how often the resident needs to be repositioned.

- **"Locked unit" or secured area** (e.g., wander guards, door alarms): Where a resident is on a locked unit or secured area to prevent wandering, the locked unit is considered an intervention that happens once. A code of "1" applies in this situation. If additional interventions to manage wandering are required, then a higher score may apply, depending on how often the additional intervention is carried out.

- **Medications:** Chemical interventions aimed at controlling the potential for injury or ineffective coping behaviours (medication administration) are scored as "1."

C. Ineffective Coping

Ineffective coping refers to the presence of behaviours that reflect an inability to deal appropriately with routine situations or individuals, and require interventions that are aimed at altering the ability to cope. Examples of behaviours that could lead to ineffective coping include any of the previously reviewed behaviours (IV. A, RCF) that require intervention.

Interventions—Ineffective Coping

The Ineffective Coping indicator is intended to reflect the amount of care the resident requires to control the behaviour in question. The need for intervention during the 24-hour period should be recorded whether or not the behaviour occurs (i.e., if intervention is actually preventing the behaviour and continues to be necessary to prevent the behaviour, it should be recorded). Staff need to be alert to the tendency to regard chronic behaviour patterns as "normal."

Interventions may be physical, nursing, medical, or pharmacological aimed at limiting, controlling, or eliminating behavioural problems. Interventions can include redirection, behavioural modification, retraining, social interventions, or restraint (physical or chemical).

The interventions are aimed at changing the behaviours to improve coping ability, and may or may not be successful.

These interventions may be **scheduled** or they may occur **in response to** a behaviour exhibited by the resident. For example:

- The resident may respond well to planned time spent with the resident to talk about a lost loved one.

- A detailed intervention by the nurse may be stated for events when the resident is aggressive.

The times given with the descriptors under the indicator are cumulative over a 24-hour period. Intervention for ineffective coping tends to be unpredictable rather than on a routine schedule (as opposed to potential for injury, which may require a more regular routine schedule of observation/ intervention).

Guidelines for Scoring Interventions—Ineffective Coping

As with potential for injury, for ineffective coping to qualify as present, a statement of **planned intervention** for the identified behavioural problem must be documented on the care plan. The documentation must indicate that the behaviour is currently an **assessed need**, what **intervention** controls the behaviour, and the **frequency** with which the intervention occurs. If the interventions are not identified in the care plan but are evident as documented in progress notes, then the Ineffective Coping indicator qualifies for verification. If no statements of planned intervention for the behavioural problems are found in any of the documentation sources, then the indicator does not qualify for verification and is scored as "0."

When interventions are documented, select the score that reflects the level of intervention required to alter the coping patterns. Remember that the interventions may or may not be successful.

Very few residents require the highest level of intervention. For the Ineffective Coping indicator to receive a score of "3," the following criteria must be met:

- Interventions are required daily.

- Interventions are **ongoing** throughout the day and evening shift, and may include the night shift.

- The interventions are very focused on the behaviour and may require large blocks of time.

- Up to 20 interventions of 6 minutes each or 10 interventions of 12 minutes each or a similar combination is required during the 24-hour period.

Behaviours During Activities of Daily Living (ADLs)

When the interventions for behaviours are being carried out at the same time as an ADL activity (classification indicator), the following guidelines apply:

- If the level of intervention required for ADL activities is higher as a direct result of the behaviour, then the higher level of intervention will be captured in the ADL indicator. Consequently, the behaviour will not qualify under the BDL indicators. For example, if two or more people need to do a transfer as a direct result of aggressive behaviour, then the level of intervention will be captured under the Transferring indicator and receive a score of "4" (requires two or more people ...).

- If the behaviour occurs outside of ADL activities or concurrently with ADL activities and requires **additional** interventions as a result of the behaviour, then the appropriate behaviour indicator applies. For example, if a resident is aggressive during dressing and another staff member must be present to calm the resident while the other staff member dresses the resident, then the additional intervention for the aggressive behaviour would qualify under Ineffective Coping.

D. Rehabilitation for BDL Domain

The goal of the program as documented in the health care record should be used to identify the type of program the resident is on. Be sure to check with the

occupational and physical therapists in the facility if there is no documentation in the record.

Definitions

Consult: A requested assessment for a specific problem that can be resolved without the resident being on a regularly scheduled intervention of treatment.

Monitor: A scheduled intervention to check or monitor ongoing status of the resident.

Low Maintenance: The goal is to ensure that the resident remains at the optimal functional level allowed by the disease process with minimal or decreasing intervention. This resident is at a plateau.

High Maintenance: The goal is to provide a continuing program of therapy which will:

- Maintain physical and mental status at optimum levels.
- Ensure continuing comfort (pain management).
- Maintain a therapeutic environment for optimal resident functioning.

Restoration: Goal is to improve optimal functional level within a specified time frame or to achieve possible discharge.

E. Frequently Asked Questions about BDL Indicators

1. **QUESTION:** For the Ineffective Coping indicator, I thought that I was supposed to pick only one of the resident's behaviours—the one that occurs most frequently—and to code it according to interventions specific to that problem. Is this correct?

   ANSWER: No. The 15 behaviour indicators that are reviewed provide you with an orientation to the intervention options that may be available for those behaviours causing problems that require intervention. Generally, the interventions that will be provided for behaviours will be a result of the combination of behaviours that the resident has. You should code the classification indicators according to the interventions provided by nursing to deal with behaviours in general.

2. **QUESTION:** If a resident is on an anti-psychotic medication but there is no documentation about a behaviour problem

   related to psychosis, how do you code ineffective coping?

   ANSWER: Chemical interventions are considered interventions to manage behaviours. If the resident is on an anti-psychotic drug, it is likely controlling some kind of behaviour. What you should be looking for in the record is evidence that a behaviour is being controlled. Because of the drug, the resident may not exhibit the behaviour and as a result, the intervention is successful. You may need to look at information in the resident history or clarify with the nurse the reason for the anti-psychotic drug before a decision can be made on this indicator. If it is controlling a behaviour, code "1."

3. **QUESTION:** If a resident is on Dilantin but there is no history of recent seizures, and there are no other interventions, how do you code potential for injury?

   ANSWER: If the administration of Dilantin is controlling the seizures, then this represents a chemical intervention. You will code "1" under Potential for Injury.

4. **QUESTION:** How do you code unsafe smoking for someone who is at risk for seizures or tremors?

   ANSWER: The behaviour may be unsafe

smoking because of the risk of seizures, but what is the intervention? You did not mention whether there was an intervention. If the resident is supervised in some way for smoking, you would code the Potential for Injury indicator according to the frequency of smoking and the resulting supervision required. Typically, this will be coded as "1."

5. **QUESTION:** The care plan states that the resident should be supervised when smoking but that he resists supervision and tries to get away from the nurse. That is the only behaviour noted. The care plan also states that the cigarettes of the resident should be kept at the nurses' station and that a nurse sits with the resident during smoking. I have coded "1" for Potential for Injury and "1" for Ineffective Coping because the resident tries to get away from the nurse. Although nothing is stated in the care plan, it is obvious that the nurse will be doing something to make sure that the resident does not get away from her when he is smoking. Is this correct?

   ANSWER: No. The definitions for the behaviours clearly state that interventions must be documented in the care plan in order to be included. Because there is no intervention stated for the efforts of the resident to get away from the nurse, you will code "1" for Potential for Injury (reflecting the supervision of smoking), and "0" for Ineffective Coping.

6. **QUESTION:** As long as there is a note about interventions for ineffective coping in the care plan, I can code the response that is appropriate—is that correct? I do not need to look for documentation in the progress notes?

   ANSWER: This is a difficult question. Generally speaking, one expects that any interventions documented in the care plan are actually implemented. You should have evidence that the level of interventions that are stated in the care plan are in fact happening. This is particularly true when there are many interventions listed related to ineffective coping (e.g., spend five minutes with the resident every hour to reassure her while she becomes used to the facility). If many interventions are documented and no substantiation is reflected in the progress notes, you should verify with the nurse the extent of interventions actually implemented.

7. **QUESTION:** I am not sure that I understand the differences in interpretation for the indicator Agitated Behaviour. In other words, what do "major changes," "minor changes," and so on mean?

   ANSWER: Generally, you can interpret as follows:

   - "Major changes" can be interpreted as agitation that occurs when a significant activity is changed, such as a rearrangement of furniture, time of day for bathing, etc.
   - "Minor changes" may be interpreted as agitation that occurs when little things are changed, such as the order of putting on clothes, tray set-up sequence, etc.
   - "Without stimulus" may be considered agitation that occurs without provocation or for no identifiable reason.

8. **QUESTION:** If a resident refuses to participate in activities, should I code the highest level for "resident acts sad, depressed"?

   ANSWER: Alterations in behaviour relate to the *normal* behaviour of the resident. Some residents may choose not to participate

in activities simply as a part of their normal behaviour. Usually, if someone is really depressed, changes may be related to eating and sleeping patterns, not only general activities. Be careful that you do not prejudice a resident simply because he/she prefers to be alone!

9. QUESTION: If a behaviour, and therefore the associated intervention, has not occurred in the past 24 hours and is happening sporadically—three to five times a week—how do I score it?

   ANSWER: At that frequency, the appropriate behaviour indicator can be scored at the highest level of intervention required. If the behaviour occurs very occasionally—less than weekly—the appropriate code is "0." The general intent of your answer selection depends on the plan that the nursing staff must be ready to implement. At three to five times a week, the staff are likely ready to implement the intervention every day.

10. QUESTION: What are examples of physical conditions that qualify for consideration in the Potential for Injury indicator?

    ANSWER: The most common conditions are:

    - at risk for falls
    - unsteady gait
    - choking (outside of mealtimes).

    The behaviour observed as a result of the physical condition is that the resident is at risk for injury to self or others, and requires intervention to reduce or eliminate the risk.

11. QUESTION: If the care plan states that due to an unsteady gait, the resident should be assisted at all times when walking, but also stated "as staff time permits," do I code what is actually done or what should be done?

    ANSWER: The classification of residents is based on the *needs* for care. In these situations, you may need to verify what is being *implemented most of the time*. If the staff assist with walking most of the time (i.e., potential for injury intervention), then the frequency of the intervention should be coded. The same guideline applies when unusual amounts of care have been identified in the management of other behaviours.

12. QUESTION: Is overeating a behaviour that can be included as "other"? The care plan states that the resident must be encouraged to eat the right food.

    ANSWER: What is the behaviour indicator you will choose? Ineffective Coping? If the care plan indicates that the intervention is directed at assisting the resident to cope, you can code "1" for this indicator.

13. QUESTION: If a resident is allergic to bee stings and a bee-sting kit must be taken whenever the resident goes outside, is this a potential for injury?

    ANSWER: Given that this would likely be an occasional intervention (i.e., less than weekly), it is not appropriate to include it as an intervention under Potential for Injury. If, however, the resident goes outside at least weekly (e.g. summertime) then the intervention would qualify as Potential for Injury.

V. Continuing Care Levels

The Urinary and Bowel Continence indicators for the continuing care level deal with the incontinent condition of the resident and the interventions required to manage the incontinence.

A. Urinary Continence

The Urinary Continence indicator addresses any inappropriate voiding causing hygienic or health risk. For this indicator to apply, residents experience an **involuntary** loss of urine in a sufficient amount or frequency that it constitutes a social and/or health problem—i.e., resident has no urethral sphincter control.

Definitions

Catheter Care: Refers to insertion and maintenance of a catheter, and cleansing and inspection of the perineal area to avoid infection and skin breakdown.

Management Procedures: Refers to the use of bladder-management programs to avoid incontinent episodes (e.g., scheduled toileting, habit toileting, and intermittent catheterization). Also refers to management procedures related to use of incontinence products that are regularly changed (e.g., adult diapers that are changed four to six times per day due to incontinence).

Retraining: Refers to the teaching and supervision of self-catheterization and programs that are used to restore a normal pattern of voiding and continence by progressive lengthening or shortening of toileting intervals, with a variety of adjunctive techniques (e.g., exercises to strengthen the muscles of the pelvic floor; providing instructions or techniques to help empty the bladder completely). Resident must be cognitively alert to participate in a retraining program.

Note: Habit training is to be distinguished from bladder retraining. Habit training such as scheduled toileting is a management procedure.

Guidelines for Scoring

Residents who experience stress incontinence or dribbling receive a score of "1" if there are no management procedures in place. Such residents are considered to be **occasionally** incontinent. However, if residents are able to manage their occasional incontinence **independently** (i.e., self-care), then a score of "0" is given.

Management procedures refer to those procedures or programs that are put in place to **avoid** or **prevent** incontinence episodes. Consequently, if a resident is continent due to management procedures currently being used, or because he/she is on a retraining program (and would be incontinent without the procedures/program), code "2" or "3" on the indicator as applicable. Note that condom drainage is considered a management procedure.

To obtain a score of "3" for bladder retraining, the resident must be cognitively alert in order to participate in a retraining program.

For cognitively impaired residents, two additional guidelines apply:

- Cognitively impaired residents who are able to control their bladder (have control over the urethral sphincter) but display some behaviour problem requiring intervention (e.g., they void in inappropriate places) are considered **continent**. Interventions to manage a behaviour problem such as reminding, redirection and toileting Q2H should be identified under the appropriate Behaviour of Daily Living—either Potential for Injury or Ineffective Coping.

- Cognitively impaired residents who are no longer aware that they need to void because of the physiological changes in the brain associated with the dementing process and require management interventions such as Q2H toileting and/or use of incontinence products are considered **incontinent**. The interventions are management procedures and are coded as a "2."

B. Bowel Continence

The Bowel Continence indicator addresses inappropriate bowel elimination causing hygienic or health risk. For this indicator to apply, residents experiencing bowel incontinence, or fecal incontinence, experience an **involuntary** loss of stool

in a sufficient amount or frequency that it constitutes a social and/or health problem—i.e., resident has no anal sphincter control.

Bowel continence must be differentiated from constipation. The Bowel Continence indicator does ***not*** apply when a resident is constipated, unless the constipation results in incontinence. In other words, chronic constipation in an older person can lead to fecal impaction which may irritate the rectum and result in the oozing of bowel mucus and other fluids. Such leaking of fluids is considered to be incontinence. However, residents who are constipated may not experience oozing, because the bowel routine for constipation prevents it.

Definitions

Management Procedures: Refers to the use of bowel management programs to avoid incontinent episodes (e.g., toileting at a regular time after meals when stimuli from hot beverages or food will trigger defecation). Does not include routine ostomy care.

Retraining: Refers to programs of toileting used to restore a normal pattern of bowel continence, and the teaching and supervision of ostomy care. Resident must be cognitively alert to participate in a retraining program.

Note: Habit training is to be distinguished from bowel retraining. Habit training such as toileting 30 minutes after a meal is a management procedure. This management procedure may be used when the fecal incontinence is due to neurologic disorders. Residents with uninhibited neurogenic incontinence may pass formed stools once or twice a day into the bed or clothing.

Guidelines for Scoring

First, the classifier must determine if the resident is indeed incontinent. It may be necessary to refer to the bowel record to determine how often a bowel movement has occurred. In addition, the classifier must confirm that any bowel management procedures in place are for the purposes of incontinence, not to avoid or manage constipation.

Use of suppositories and enemas—Suppositories and enemas may be used for a number of purposes. The following guidelines apply when scoring the Bowel Continence indicator:

- The use of and purpose for suppositories and enemas must be clearly indicated in the nursing care plan. If there are facility policies for the standard management of various bowel conditions (e.g., constipation, neurogenic fecal incontinence), the policies must be reviewed.

- If a resident is on suppositories/enemas to manage constipation, and the resident is incontinent following the administration of the suppository/enema, code "1" for occasional incontinence.

- If a resident is on **daily** suppositories/enemas to manage incontinence due to fecal impaction, code "2."

- If a resident is on suppositories/enemas **two to three times a week** due to neurogenic fecal incontinence, code "2."

- If a resident is given a suppository or enema on **two consecutive days** for the purpose of retraining, code "3."

C. Medications

Medications include oral, subcutaneous, IM and IV drugs. Topical medications should not be counted here; these should be included under "Therapeutic Interventions - Other."

Scheduled medications are those given on a predetermined schedule. PRN medications are those given at the nurse's discretion only when the resident requires them. Standing orders should not be counted unless they have been taken by the resident in the preceding 24-hour period. They should then be counted as a PRN medication ordered and taken.

Note that "number of medications" refers to the number of *different* drugs that are currently prescribed, *not* the number of doses ordered.

Note also that all coding boxes must be filled in (e.g., if a resident took two scheduled medications during the preceding 24-hour period, this should be coded "02" as opposed to "2").

1. Record number of scheduled medications currently ordered.

2. Record number of scheduled medications taken during preceding 24-hour period.

3. Record number of PRN medications currently ordered.

4. Record number of PRN medications taken during preceding 24-hour period.

5. Record total number of medications taken during preceding 24-hour period (PRN and scheduled).

Note: If a drug is ordered on a schedule and PRN, count the drug as both scheduled and PRN if different purposes are identified. If different purposes are not identified, count the drug *only* as scheduled.

D. Communication (Verbal or Non-Verbal)

Communication refers to the resident's ability to exchange verbal and non-verbal information. If there is no communication impairment (i.e., if a "0" was coded for this item), code "0" in the next three coding boxes. If there is some communication impairment (i.e., if a "1," "2," or "3" was coded for this item), note the source(s) of the communication problem (physical impairment, language barrier, or cognitive impairment). Code a "0" if the sub-item does not give the source of the communication problem, or a "1" if it does give the cause of impairment. (A "1" must be recorded in at least one of the three boxes under "D" if there is some degree of communication impairment.)

E. Frequently Asked Questions about CCL Indicators

1. **QUESTION:** If a resident wears incontinence products, they are not really being managed, are they?

   ANSWER: For the CCL indicator Urinary Continence, the application of incontinence products is considered managed care. Remember that the definition relates to providing care to the resident to avoid hygiene or health risk.

2. **QUESTION:** If a resident has stress incontinence and wears and changes ATTENDS on his/her own, should I code "2" for Urinary Continence?

   ANSWER: No. If the resident makes the changes herself, this is no different than any other kind of self-care. You will code "0" for Urinary Continence.

3. **QUESTION:** If the resident has stress incontinence and wears a sanitary napkin that is changed by the nurse once a shift, how do I code urinary continence?

   ANSWER: This is a tricky question. Because the change of the napkin is only once a shift, we have to assume that the resident is not continuously incontinent. Given the intent of the levels of intervention, the correct response would likely be to code "1." If the napkin was changed more frequently, a code "2" would be appropriate.

4. **QUESTION:** If the care plan states "toilet Q2H" and "no fluids after 8:30 PM," do I code "2" for Urinary Continence?

   ANSWER: You are assuming that the resident is incontinent and these procedures are managing the incontinence. Before you code "2," you should confirm that in fact the resident would be incontinent without these

procedures. In some facilities, such care plan initiatives have become routine, not necessarily because of need, but because of routine. Be careful to differentiate the two.

5. **QUESTION:** If the resident is on a bowel routine to manage constipation, do I consider this a management procedure?

   ANSWER: No. However, if the resident is incontinent when the bowel routine is administered, code "1."

6. **QUESTION:** How do I code condom drainage?

   ANSWER: Code "2" under management procedures. Condom drainage is considered as an intervention similar to the use of incontinent products.

VI. Therapeutic Interventions

1. Treatment must be current and should be provided by regular staff who ordinarily are employed by the facility but may be hired on a contractual basis.

2. A physician order must be written, specifying the cause/need for this treatment and the frequency. If the treatment (e.g., suctioning) was given on an emergency basis, the treatment may be counted even if no written order is on the resident's chart.

3. Code "0" if the treatment is not given at least monthly.

   Occasional: If the treatment is given at least monthly, but not weekly, code "1."

   Frequent: If the treatment is given at least weekly, but not daily, code "2."

   Constant: If the treatment is given at least once a day, code "3."

Definitions

IM Therapy: Intra muscular injection of medication.

Subcutaneous Injection: Any subcutaneous injection, except insulin injections, given on a sliding scale.

Insulin Injection on a Sliding Dosage: The amount of insulin to be administered is determined by the level of sugar in the resident's blood or urine on a test performed prior to the administration of the insulin.

Sterile Dressing Changes: Use of aseptic technique to change dressing on any type of wound.

Other Wound Care: Care of subcutaneous lesions resulting from surgery, trauma, or open ulcers. Includes wound debridement, use of ultraviolet light, and other special treatments to facilitate wound healing.

Oxygen: Administration of oxygen without medication per nasal cannula, mask, hood, or artificial airway.

Chest Care: Includes nebulizations, delivery of aerosol medication, postural drainage, percussion, vibration, and assisted coughing and deep breathing.

Nasal/Oral Suctioning: Removal of secretions from airway and pharynx (excludes suctioning of tracheostomy).

Tracheostomy Care: Includes removal and cleansing of tracheostomy, cannula, and suctioning to maintain a patent airway.

Nasogastric (Tube) Feeding: Administration of oral feedings and medications through nasal-gastric and oral-gastric tubes to maintain nutritional status.

Gastrostomy (Tube) Feeding: Administration of feeding through a tube inserted directly into the stomach.

Parenteral Fluids: Routine administration of TPN, hypodermoclysis, or IV fluids. Inspection and maintenance of IV or central line.

Other: If other therapeutic interventions are being received by the resident, a "1," "2," or "3" should be coded beside "other" *and* treatment(s) should be specified under this item. If not, a "0" should be coded beside this item *(do not leave the box blank)*. Topical medications such as physician-ordered lotions, ointments, creams, eyedrops, or transdermal preparations (i.e., nitroglycerine) should be included here. If more than one treatment is being recorded here, the frequency code ("1," "2," or "3") should refer to the first treatment listed.

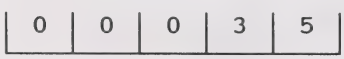
VII. External Demand Level

Family Participation in Care: These items refer to any behaviour of the resident's family or friends that either increases or decreases the resident's or the family's or friends' need for care/assistance. This includes any behaviour that alters the resident's need for assistance from staff by decreasing the resident's demands on staff or by increasing the family's demands on staff.

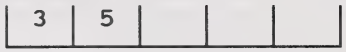
Date of Classification: Record the date on which the Resident Classification Form was completed for that particular resident.

Note: All coding sections (boxes) must be filled in for this item (i.e., if the month or day is between one and nine, it should be coded "01," "02," etc., as opposed to "1," "2," etc.).

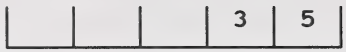
Classifier Code: Record the appropriate unique identifier code (a different code is assigned to each classifier). This number should be aligned to the *right* of this coding section. For example, if the code number is "35," it should be coded:



as opposed to



or



VIII. Frequently Asked Questions About Other Indicators

1. **QUESTION:** Should Ventolin be considered a medication or a treatment?

   ANSWER:

   The following should be included as *medications*:
   - Ventolin, Beclovent, and similar agents
   - Suppositories, including glycerin suppositories
   - Nitro sublingual (SL)

   Include as *treatments*:
   - Eye drops
   - Enemas
   - Creams (including nitropaste)
   - Pain patches
   - Nicotine patches

2. **QUESTION:** The resident has had a flu shot. Should I count it as a medication?

   ANSWER: Your question relates to two issues. What is a medication and how often a medication is given. First, the flu shot is not a medication, but rather an immunization shot. Second, the flu shot is generally given annually. Other therapies or medications such as mantoux tests, vitamin B_{12} and monthly psychotropic injections are excluded as medications because they are given monthly or less often.

3. **QUESTION:** This facility inserts a standing-order sheet in every chart for all possible PRN medications that could be given to a resident. Do we consider that all of these medications have been ordered as PRN?

   ANSWER: Standing orders are generally considered applicable only if the resident has actually made use of the drug. Review the medication administration record for the past month. If any of the standing order PRN drugs have been administered, you can include them as ordered. Of course, they will be coded as taken only if they have been taken in the last 24 hours.

4. **QUESTION:** Are TED stockings a treatment?

   ANSWER: Yes, if ordered by a physician. Code as "other."

5. **QUESTION:** If the family visits monthly, what should I code?

   ANSWER: Monthly visits are coded "less than weekly."

6. **QUESTION:** If the facility does not have an occupational therapist on staff, but residents receive OT from a therapist who visits the facility, what do I code?

   ANSWER: If the resident pays for the OT service, code "8." If the facility pays for the OT service, code "0."

7. **QUESTION:** Recreation therapists do more with residents than physiotherapists. Why are there no indicators for them? Can I use the PT indicators for recreation therapists?

   ANSWER: No. Although the thinking has changed with regard to this, at the time of the development of this tool, recreation therapists did not generally work one on one with individual residents. Most of the activities of recreation therapists were in groups. They were not included as a part of the individual resident assessment. The current classification procedure includes only physiotherapists and occupational therapists.

IX. Instructions for Determining Classification Categories from the Resident Classification Form

In determining a resident's classification category, it is important to note that only part of the information from the Resident Classification Form is used. To determine a resident's category, you will be recording a resident's scores on the following indicators from the Resident Classification Form:

- Eating (indicator III.A)
- Toileting (indicator III.B)
- Transferring (indicator III.C)
- Dressing (indicator III.D)
- Potential for Injury to Self or Others (indicator IV.B)
- Ineffective Coping (indicator IV.C)
- Urinary Continence/Catheter Care (indicator V.A)
- Bowel Continence/Ostomy Care (indicator V.B)

You will *not* need the information from the other items on the form (e.g., background data or health status) for classification purposes; these items are used for other reasons such as tracking changes in the needs of the long term care facility population over time.

Note: Classifiers are not required to do these calculations.

Classification categories for residents are determined using the process described on the following pages.

Instructions for Determining a Resident's Classification Category

Step 1: Record resident's score from the RCF for the ADL, BDL, and CCL indicators in the boxes in section I of the worksheet.

Step 2: Determine resident's **ADL Level of Care** as follows, based on scores in Step 1. Record in ADL box in section II of worksheet.

1 **Low:** Has no score higher than 1 on any of the four ADL indicators.

2 **Med Low:** Has at least one score of 2 but no scores higher than 2 on any of the four ADL indicators.

3 **Med:** Has at least one score of 3 but no scores higher than 3 on any of the four ADL indicators.

4 **Med High:** Has a 4 or 8 on at least one indicator, but does not meet the requirements for "high" ADL level.

5 **High:** Must have a 4 or 8 on one or both Eating and/or Dressing, **AND** a 4 or 8 on one or both Toileting and/or Transferring.

Step 3: Determine resident's **BDL Level of Care** as follows, based on scores in Step 1. Record in BDL box in section II of worksheet.

1 **Low:** Has a 0 or 1 on the Potential for Injury indicator, **AND** a 0 on Ineffective Coping.

2 **Med:** Has a 2 on the Potential for Injury indicator, and a 0 or 1 on Ineffective Coping; **OR** a 0 or 1 on Potential for Injury and a 1 on Effective Coping.

3 **High:** Has a 3 on the Potential for Injury indicator and a 0 or 1 on Ineffective Coping; **OR** a 0, 1 or 2 on Potential for Injury and a 2 on Ineffective Coping.

4 **V. High:** Has a 3 on the Potential for Injury indicator and a 2 on Ineffective Coping; **OR** any score on Potential for Injury and a 3 on Ineffective Coping.

Step 4: Determine resident's **CCL Level of Care** as follows, based on scores in Step 1. Record in CCL box in section II of worksheet.

0 **None:** Has a score of 0 on **both** Continence indicators.

1 **Low:** Has a score of 1 on either or both Continence indicators, but no scores higher than 1 on either Continence indicator.

2 **Med:** Has a 2 or 3 on **either** Continence indicator, but not both Continence indicators.

3 **High:** Has a 2 or 3 on **both** Continence indicators.

Step 5: Use the matrix following the worksheet to determine resident's classification category based on ADL, BDL, and CCL levels of care (Steps 2, 3, and 4).

- Locate appropriate ADL level.
- Locate appropriate BDL level.
- Locate appropriate CCL level.
- Record letter from the cell in the matrix in which the resident's ADL, BDL, and CCL levels meet, in classification category box in section III of the worksheet.

Classification Category Worksheet

Section I

ADL Indicators	BDL Indicators	CCL Indicators
☐ Eating	☐ Potential for Injury	☐ Urinary Continence
☐ Toileting	☐ Ineffective Coping	☐ Bowel Continence
☐ Transferring		
☐ Dressing		

Section II

ADL Level of Care	BDL Level of Care	CCL Level of Care
☐	☐	☐

Section III

Classification Category

☐

Matrix for Classifying Residents Based on ADL, BDL and CCL (Continence) Levels

ADL LEVEL	BDL LEVEL	CCL (CONTINENCE) LEVELS			
		0 - None	1 - Low	2 - Med.	3 - High
1 - Low	1 - Low	A	A	A	D
	2 - Med.	B	B	B	D
	3 - High	B	B	B	D
	4 - V. High	C	C	C	D
2 - Med. Low	1 - Low	B	B	B	D
	2 - Med.	B	B	B	D
	3 - High	C	C	C	D
	4 - V. High	D	D	E	E
3 - Med.	1 - Low	C	C	C	D
	2 - Med.	C	C	C	D
	3 - High	D	D	E	E
	4 - V. High	E	E	F	F
4 - Med. High	1 - Low	D	D	E	E
	2 - Med.	D	D	E	E
	3 - High	D	D	E	E
	4 - V. High	F	G	G	G
5 - High	1 - Low	E	F	F	F
	2 - Med.	E	F	F	F
	3 - High	E	F	F	F
	4 - V. High	G	G	G	G

NOTES